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Getting there together professional development course: shared-decision making in wheelchair evaluations

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GETTING THERE TOGETHER PROFESSIONAL DEVELOPMENT COURSE: SHARED-DECISION MAKING IN WHEELCHAIR EVALUATIONS

by

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DEDICATION

I would like to dedicate this work to my loving and patient partner, Rémy Olson. He encourages me to set big personal goals and expresses never ending support in their achievement. Thank you.

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ABSTRACT

The wheelchair evaluation process is complicated for clinicians and consumers alike. Consumers report feeling uninvolved in the wheelchair evaluation process resulting in feeling uniformed and dissatisfied and in some cases, being prescribed wheelchairs that do not meet their needs. Consequently, consumers may abandon the recommended wheelchair which may impact participation in Mobility-Related Activities of Daily Living (M-RADLs). Shared Decision Making (SDM), used in healthcare encounters, may be used by clinicians to facilitate a collaborative process when recommending wheelchairs. This project proposes a continuing education course designed to teach the principles of SDM and guide clinicians' implementation of SDM into their practices.

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LIST OF ABBREVIATIONS

AOTA	American Occupational Therapy Association
AT	Assistive Technology
GTT	Getting There Together
M-RADL	Mobility Related-Activities of Daily Living
SDM	Shared-Decision Making

CHAPTER ONE: INTRODUCTION

The Problem

The American Association of Occupational Therapy (AOTA) Code of Ethics states that occupational therapy practitioners must respect a person's agency and "acknowledge a person's right to hold views, to make choices, and to take actions based on his or her values and beliefs [and] fully disclose the benefits, risks, and potential outcomes of any intervention" (AOTA, 2015, p. 4). Despite this core value of occupational therapy, researchers have documented that consumers who may need a wheelchair for mobility have limited participation in the selection of mobility-related assistive technology (AT). Lenker, Harris, Taugher, & Smith (2012) reported that consumers identified four factors that acted as barriers in the AT acquisition process: The need for service providers to elicit and value consumer input, funding, quality of service providers, and complexity of the process. Greer, Brasure, & Wilt (2012) conducted a review of existing standards of wheelchair service delivery and found that "consumer representatives were concerned that many persons lack the necessary knowledge of the wheeled mobility delivery process and available resources" and suggest greater consumer involvement in the selection process to decrease potential abandonment of the recommended AT (p. 144). The lack of consumer participation in the decision-making process may contribute to consumers' dissatisfaction with and lack of participation in mobility-related activities of daily living (MRADLs). In fact, Martin, Martin, Stumbo & Morrill (2011) reported a statistically significant relationship between consumers feeling that personal needs were not assessed and lower satisfaction with their AT device. The 16

consumers who participated in Martin and colleagues study stated they felt uninformed about making mobility-aid decisions reported not having enough information (31.3%), not knowing all the options (56.3%), not knowing where to find information (37.5%), or feeling their needs were not assessed (31.3%) as factors contributing to their satisfaction (Martin et al., 2011).

Consumers are reporting dissatisfaction, limited information, and lack of participation in the wheelchair evaluation process that results in long-term negative impacts on participation in mobility-related activities of daily living (MRADLs). To understand this problem, this project is guided by an accessibility framework and reviews the research evidence. The proposed solution based on shared decision making and focuses on educating practitioners to engage in collaborative relationships with consumers during the evaluation and wheelchair prescription process.

CHAPTER TWO

Conceptual Framework

The limited participation in decision-making related to selecting wheeled mobility devices can be understood by examining the accessibility of the wheelchair procurement process. Accessibility can be defined as "the interface between potential users and health care resources" (Levesque et al., 2013, p. 2). Levesque and colleagues view access from the consumer perspective focusing on the consumer's ability to "identify healthcare needs, to seek healthcare services, to reach, to obtain or use healthcare services, and to actually have a need for services fulfilled" (p. 1). They conceptualized accessibility in five dimensions: (1) Approachability, (2) Acceptability, (3) Availability, (4) Affordability, and (5) Appropriateness. Approachability focuses on consumers' ability to understand the benefits of health services or products.

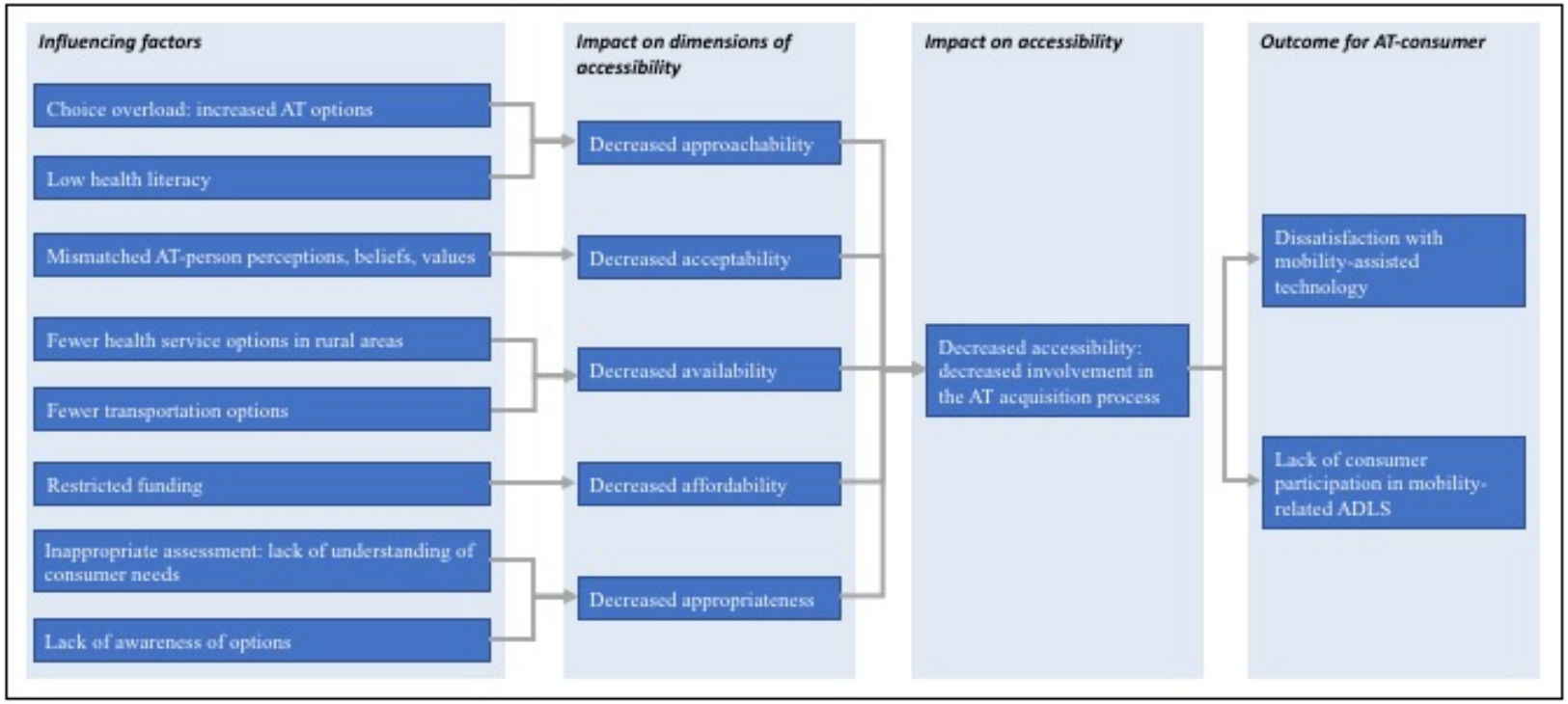

Figure 1. Visual Model of Framework.

Consumers' abilities to understand the potential benefits of services or products are affected by the consumers' health literacy and how well an organization presents information to meet consumers' needs. Acceptability relates to consumers' personal and social values and their perception of the value and usefulness of healthcare service or products. Availability is defined as consumers' ability to reach the service based on geographic location and transportation options to travel to the service delivery agency. Affordability is related to product costs, consumers' capital, or access to insurance. Appropriateness is the fit between the services or products and consumers' need. In this model, appropriateness and acceptability are considered distinct dimesons, although within the occupational therapy lens, AT that was not acceptable to the consumer would not be considered appropriate. Levesque et al. (2013) accessibility framework is used to understand the potential causes for lack of consumer engagement in the wheelchair procurement process.

Approachability

Approachability is how easy or difficult is it for consumers to understand information regarding available interventions and products (Levesque et al., 2013). Approachability is facilitated at the provider-level by the information and transparency provided by the practitioner and the consumer's health literacy, health beliefs, trust and expectations of the provider also impact the consumer's understanding of the information related to intervention or recommended mobility devices. The approachability of the wheelchair procurement process is influenced by the vast number of AT options that a consumer can chose from. In economics, the term "choice overload" has been used to

describe the idea that increased choice options results in decreased consumer motivation to choose and increased dissatisfaction (Iyengar & Lepper, 2000). Moreover, if written and verbal information, about potential AT options is presented in a format and level that is not congruent with the consumer's health literacy abilities, the approachability of the recommended AT device may be compromised.

Choice Overload: Increased AT Options

There are more customizable wheelchair and technology options than ever before (Kirshner, 2014). Recent trends in mobility-related AT have focused on optimizing the user-technology fit to maximize user abilities (Cowen et al., 2012). While increased options may lead to optimization of the AT-person fit, it becomes more difficult for healthcare providers to be aware of and be able to communicate the range of technology to the consumers. Service providers and consumers alike have identified increased technology options as a barrier to accurate wheelchair prescription (Lenker et al., 2012).

Low Health Literacy

The National Assessment of Adult Literacy, conducted by the U.S. Department of Health and Human Services (2008) reported that 35% of adults in America have basic or below basic health literacy. Specifically, the Institute of Medicine reported that ninety million American adults have limited health literacy (National Institutes of Health [NIH], 2018). Poor literacy skills are a strong predictor of poor health outcomes (Weiss, 2003). People with low literacy have challenges with their "ability to read and process information… may get distracted easily, give up quickly, and struggle with dense text" (Office of Disease Prevention and Health Promotion [ODPHP], 2018). Literacy is not

linked to a specific demographic (Agency for Healthcare Research and Quality, 2020; National Institute of Health, 2020). In fact, mismatches between the average reading level of the intended population and the instructional materials, health documents, or handouts provided were identified across healthcare settings (Bastable et al., 2011; Lerner, Jehle, Janicke, & Moscati, 2000; Meyers & Shephard-White, 2004; Sudore & Landefeld et al., 2006; Walfish & Ducey, 2007). Verbal or written information that does not match consumers' literacy needs may decrease consumers' ability to understand options and make informed choices.

Acceptability

A person's relationship to mobility aids is complex and nuanced as it encompasses an individual's negotiation of personal identify, values, beliefs, and perceived societal values and beliefs, which, in turn, determine how acceptable they perceive the recommended mobility aid. Shinohara & Wobbrock (2016) noted that abandonment of AT and willingness to adopt AT is related to the individual's self-concept about using the AT and this self-concept may in turn influence consumers' perception of the usefulness of the recommended AT. In a 2016 study of user perceptions of their AT, participations kept diaries over a month regarding their experiences with AT use (Shinohara & Wobbrock). The researchers reported numerous social factors that influence consumers' perceptions of AT including the reactions and perceptions of others, the influence of AT on social interaction, how well or poorly the AT functioned, the social context the AT was used in, and the expectations of AT held by self and others (Shinohara & Wobbrock, 2016). Mortenson & Miller (2008) interviewed wheelchair

users and found that perceived stigma led some users to abandon their wheelchairs. Mobility-related AT influences self-concept, potentially enhancing self-confidence or increasing self-consciousness. Therefore, understanding consumer beliefs and values during the AT acquisition process is key to enhancing AT adoption and enduring use.

Availability

Consumers' ability to interact with a health service provider is based upon the physical location of providers and transportation options. Consider that 20% of Americans live in rural areas, which means that the closest health care facility is likely to be quite a distance from their homes (Hempel et al., 2017). In order to obtain healthcare services people living in rural communities must travel long distances and incur significant costs (Weeks et al., 2008). Additionally, rural communities have difficulty attracting and retaining providers and often experience shortages of healthcare providers (Hempel et al., 2017). The consumers also have limited transportation options to get to the physical location. Expensive options in rural communities and for individuals with limited transportation options lead to decreased availability of health services to consumers.

Affordability

The cost of wheelchair bases and specific wheelchair features are often financially prohibitive to many private payers requiring most consumers to purchase assistive technology through private and federal insurance (Martin et al., 2011). In a 2017 survey of power wheelchair users and prescribers, cost was identified as a significant barrier to the uptake of appropriate technology (Gillham et al., 2017). Additionally, recent changes

to Medicare and The Affordable Care Act have "instated competitive bidding for Medicare wheelchair contracts" and private insurers are beginning to adopt similar restrictive guidelines (Kirschner, 2014, p. 643). These competitive bidding contracts limit funding for complex medical equipment including individually configured manual and power wheelchair systems. Funding can be a barrier to obtaining assistive technology (Kirschner, 2014; Lenker et al., 2012).

Appropriateness

As stated earlier, there are more AT options leading to greater potential to optimize mobility-related AT to meet the needs of consumers (Kirshner, 2014; Cowen et al., 2012). Wheelchair procurement is a complex multi-step process that involves understanding consumer needs and available options to create the best AT-person match. Therefore, the appropriateness of the resulting AT-person fit is determined by the assessment measures used to identify the consumer's need and awareness of the AT options to meet those needs. Thus, fit is established by the clinician's abilities to know and understand AT options, to communicate and explain these options to consumers, and to engage the consumer in collaborative decision-making to choose the most appropriate AT for their needs. From an occupational therapy perspective, which values patient preferences, AT options that are not acceptable to consumers are also not deemed appropriate.

Conclusion

The current wheelchair evaluation process has obstacles that can make finding a wheelchair that meets consumers' needs inaccessible. As a profession, occupational

therapy aims to empower consumer choice and autonomy, but to do so professionals must address the barriers of accessibility to better include consumers in the decision-making process. Clinicians have the ability and responsibility to address and minimize the modifiable elements of inaccessibility in order to improve consumer-AT fit and satisfaction.

CHAPTER THREE

Part I: Evaluation of Evidence on Methods

Increasing the accessibility of the selection of wheeled mobility devices can be addressed using a tiered approach at the individual, organizational, and systems levels (Child & Family Research Partnership. 2018). For the purpose of this review, the focus is on individual and organizational level changes as these factors are more easily modifiable. For example, modifying the funding structure for wheelchairs requires system-level policy change or knowledge of alternative funding mechanisms available in the local community. In contrast, changing the communication providers use with clients may support clients' understanding of health information (Spencer, 2019; Schillinger et al., 2003). Below is a summary of the factors presented in the prior framework:

Individual- and Organizational- Level Factors	**Systems-Level Factors**
Low Health Literacy Assessment: Lack of understanding of consumer needs Mismatched AT/Person perceptions, beliefs, values Lack of Awareness of Options Choice Overload	Funding Transportation Rural Areas

Figure 2. Summary of Accessibility Factors

This synthesis summarizes the current literature that describes methods that have been used to address the problems of decreased health literacy, limited understand of consumers' needs, mismatch between the AT provides and clients' perceptions, beliefs or values, clients' lack of awareness of the range of AT options to address their needs, and choice overload.

Shared Decision Model

Elwyn et al. (2012) proposed the Shared Decision Model to define and outline the process in which patients and clinicians share the responsibility of making health care decisions based on best evidence to reach educated preferences. Elwyn and colleagues revised the Shared Decision Making Model in 2017 to reflect feedback from researchers, health professionals, patients, and policy makers. The revision of the model is called "The Three-Talk Model of Shared Decision Making" (Elwyn et al., 2017). Shared-decision making (SDM) reflects the shift in healthcare practices from clinicians making decisions on behalf of an inactive patient to patient-centered or client-centered health care movement (Elwyn et al., 2017; Elwyn et al., 2012, O'Connor et al., 2007; Elwyn et al., 2010; Senate and House of Representatives, 2010). Shared-decision making is the process of clinicians, patients and their families working together to make informed and preferred medical decisions based on the provision of evidence-based accessible information about treatment options (Elwyn et al., 2017). The goal of SDM is to enhance patients' understanding of the pros and cons of various intervention options to arrive at an informed preference that integrates what matters to patients in the context of the best available evidence.

Visual Model of Principles of the Three-Talk Model of Shared Decision Making

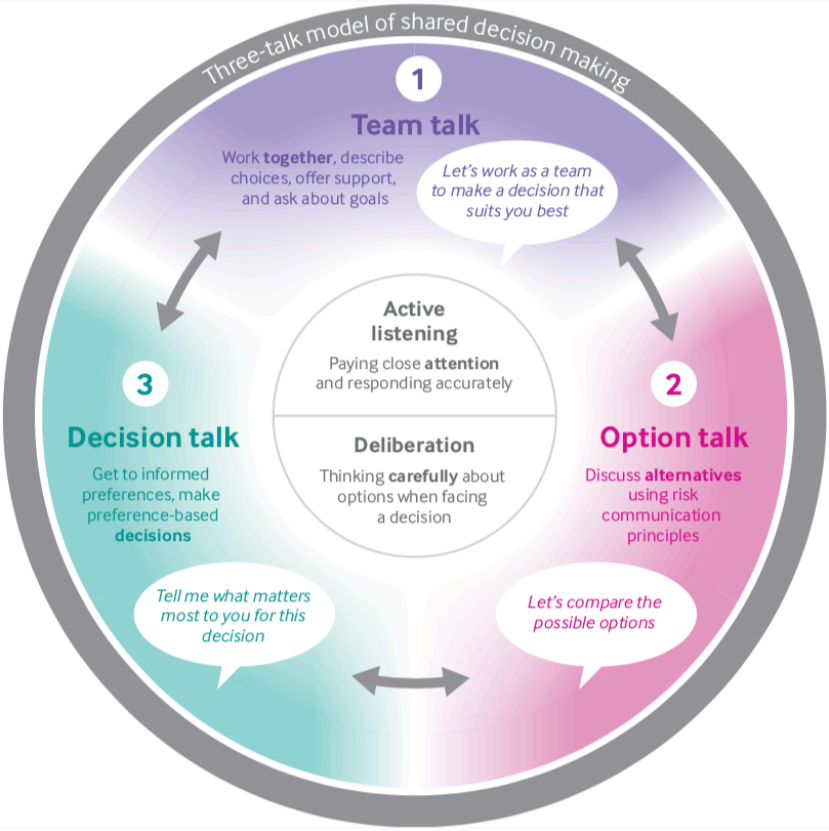

Figure 3. Three-talk model of shared-decision making from Elwyn et al. (2017)

Figure 3 provides a visual model of the dynamic process of the collaboration in decision-making conversation through three smaller "talks": Team, Option, and Decision Talk. Each of these talks focuses on specific communication goals that are described in greater detail below. Throughout the conversation, active listening and careful consideration of the options are required of all participating parties.

Team Talk

The purpose of Team Talk is for the clinician to invite the consumer to the decision-making process. The goals of Team Talk are for the clinician to introduce

potential choices, in this application a choice in wheeled mobility, understand the consumer's goals, and offer to support the decision making process (Elwyn et al., 2017). Team talk, therefore, can be thought of as the introduction to the process with emphasis on the desired outcome of the process: a decision that meets the consumer's goals.

Option Talk

Once the choice is introduced, in this case selecting a wheelchair, the various options are introduced in Option Talk. Option Talk begins with a determination of the patient's knowledge of treatment options (Elwyn et al., 2012). Once the patient's current knowledge of options has been established, the clinician can use that information to meet the person where they are by outlining the options clearly while describing the limitations and benefits of each option. As part of this talk, the clinician uses risk communication principles, which are the best practices in communicating probabilities of adverse health outcomes associated with each option (Trevena et al., 2013). These communication principles are applicable to decisions such as surgery or medication in which clear side-effects or risks are posed and can be communicated in numeric estimates (Trevena et al., 2013). In the selection of wheelchairs there are no clear risks that are calculated in probabilities that need to be communicated, therefore, the risk communication principles may need to be adapted for applying this Three-Talk model to wheelchair prescription The next step in this shared decision making process is summarizing the information presented throughout the communication to ensure comprehension. Listing the options and asking the patient to describe them is encouraged to better understand their comprehension or potential misconceptions regarding the options (Elwyn et al., 2012).

Decision Talk

Although the process is recursive as needed, in the final stage, the clinician supports and encourages the consumer to use the presented information to decide what matters most to them to elicit an informed preference (Elwyn et al., 2017). Decision Talk is the processing and internalizing of information to arrive at an informed preference-based decision. In this phase of the communication process, the patient weighs the options with their values and lifestyle to determine the best option.

Outcomes

The Three-Talk Model of shared decision making (Elwyn et al., 2017) is a guide for clients and clinicians to share the responsibility of medical and treatment decisions based on the evidence. Elwyn and colleagues suggest that use of the model may lead to a short-term outcome reflecting clients' increased involvement in treatment decisions and facilitating the evolution from initial preferences to informed preferences. The long-term outcome is that clients will be more satisfied with their treatment and health with increased involvement in related decisions.

Application

Shared-decision making has been applied across many medical and clinical fields and is often considered a golden standard in U.S. healthcare (Joseph-Williams et al., 2013; Joosten et al., 2008). Shared-decision making has been used to improve consumers' self-reports of satisfaction across medical specialties including psychiatry, oncology, dentistry, internal medicine, cardiology, community care, neurology, pulmonology, endocrinology, surgery, gerontology, and primary care (Joseph-Williams et

al., 2013; Joosten et al., 2008). Shared-decision making is used by nurses (George, 2013), occupational therapists (American Occupational Therapy Association, 2015), speech therapists (American Speech-Language-Hearing Association, 2016), and physical therapists (Dierckx, Deveugele, Roosen & Devisch, 2013).

The following sections provide an analysis of some of the current evidence for various SDM interventions across diverse populations.

Systematic reviews of shared decision-making

Description of systematic reviews

The findings of four systematic reviews of SDM as they relate to the identified modifiable accessibility factors are reviewed. First the systemic reviews are described, followed by a discussion of how specific findings can be applied to the accessibility factors that limit consumer's participation, satisfaction, and use of prescribed wheelchairs.

Durand et al. (2014) conducted a systematic review and meta-analysis of randomized control trials and observational studies of shared decision-making (SDM) interventions' impact on health inequalities among people from disadvantaged groups including knowledge, decision self-efficacy, participation in decision-making, and satisfaction with the process and results of the decision. Disadvantaged groups are defined as people who are have low socioeconomic status, ethnic minority status, low education/literacy level, and/or from geographically underserved locations (Durand et al., 2014). Shay & Lafata (2015) systematically reviewed the relationship among SDM interventions with patient affective-cognitive, behavioral, and health outcomes. Joosten et

al., (2008) examined the effects of SDM interventions on patient satisfaction with care, increase of knowledge, quality of life, and adherence to treatment. Wyatt et al. (2015) reviewed studies that utilized a SDM intervention with pediatric clients and their caregivers as associated with satisfaction with decision, decisional conflict, and knowledge.

Across the systematic reviews, there is difficulty operationalizing Shared-Decision Making (Shay & Lafata, 2015; Wyatt et al., 2015; Durand et al., 2014; Joosten et al., 2008). Shay & Lafata (2015), included studies in which the patient, observer, or the clinician indicated that SDM had occurred. Joosten et al. (2008) included studies in which steps were taken to ensure that clinician and patient were both involved in the decision-making process until discussion lead to a consensus on a treatment plan. Wyatt et al. (2015) broadly defined SDM "as the process of involving patients or their caregivers… in medical decision making with clinicians" (pg. 575). The lack of an operationalized definition makes it difficult to interpret fidelity to a SDM intervention and generalize intervention features. However, the results of these studies are still valuable as they illustrate the varied outcomes of a broad range of interventions that are unified by a goal of increasing consumer engagement in the medical decision-making process. Shay & Lafata (2015), Wyatt et al. (2015), Durand et al. (2014), and Joosten et al. (2008) used the variety of interventions to identify commonalities of the most effective SDM interventions. Interventions that led to significant increases in consumer satisfaction, adherence to treatment, and well-being occurred over more than one session (Joosten et al., 2008). SDM interventions related to long-term decisions and/or consumers

with chronic diseases had significant positive outcomes compared to specific short-term decisions (Joosten et al., 2008). Shay & Lafata (2015) found that positive patient outcomes were associated with studies in which the patient perceived that SDM had occurred as compared to observer- or clinician-rated SDM. Lastly, Durand et al. (2014), found that SDM interventions are significantly more beneficial to disadvantaged groups compared to those with higher literacy, education, and socioeconomic status.

The following sections relate the outcomes of SDM to the accessibility factors that limit consumer's participation, satisfaction, and use of prescribed wheelchairs.

Increasing Appropriateness & Acceptability

Understanding consumer needs, beliefs, and values. Appropriateness is the fit between the services or products and the consumers' need (Levesque, Harris, & Russel, 2013). *Acceptability* is the fit with consumers' values, perceptions, and beliefs (Levesque, Harris, & Russel, 2013). One of the core principles of shared-decision making is to facilitate the creation of informed consumer preferences based on the consumer's perception of his or her needs, values, and beliefs. This principle assumes the consumers' participation in the process of SDM. Durand et al. (2014) found that SDM interventions significantly increased participation in decision-making for financially, geographically, or educationally disadvantaged groups.

Increasing Awareness of Options. Introducing options and enhancing awareness is another principal of SDM. The principal assumes that consumers increase their knowledge of treatment options when provided information about the options. Wyatt et al. (2015) and Joosten et al. (2008) concluded that SDM intervention groups had

significant higher knowledge compared to controls. Durand et al. (2014) found that SDM intervention groups had a significant increase in knowledge of treatment options for patients with low socioeconomic status, low health literacy, and/or less education compared to control groups (Durand et al., 2014). In fact, Durand and colleagues reported that three studies included groups with low health literacy and a control group. The authors conclude that post-SDM intervention initial disparities of knowledge of treatment options disappeared between the two groups (Durand et al., 2014). Overall, SDM appears to increase accessibility of information that consumers can use to arrive at an informed preference based on their goals, values, perceptions, and beliefs.

Increasing Approachability

Decreasing Decisional Conflict. Approachability, or the ability for consumers to understand information regarding available treatments and products is influenced by choice overload and low health literacy (Levesque, Harris, & Russel, 2013. As noted earlier, choice overload is the concept that increased choice options results in increased decisional conflict in which decreased consumers' motivation to choose and increased dissatisfaction (Iyengar & Leppar, 2001). Durand et al. (2014), Wyatt et al. (2015), and Shay & Lafata (2015) called this outcome decisional conflict, which is operationalized as consumer self-reports of perceptions of uncertainty in decision-making. Wyatt et al. (2015) concluded that SDM interventions led to a significant reduction in decisional conflict while Shay & Lafata (2015) found a significant reduction in decisional conflict only when consumers perceived SDM occurring as compared to clinicians or observers. Durand et al. (2014) found a medium effect size for reduced decisional conflict for

people with low literacy and a narrowing of disparities between disadvantaged and control groups in five of the seven SDM studies that examined this outcome.

Communicating Complex Healthcare Information. Improved health literacy to decrease health disparities is an important goal of Healthy People 2020 (Healthy People, 2019). Strategies for clear and effective communication should be used universally as it is difficult to identify individuals with low health literacy and all people benefit from improved communication (AHRQ, 2017). To accomplish improved consumer comprehension, the AHRQ recommends written materials with verbal key messages from clinicians, simplifying communication to be specific and concrete using plain language, using simple pictures or demonstrations, repeating to summarize key points, and confirming comprehension (AHRQ, 2017; Berkman et al., 2004). Patient comprehension checks and clarifying missed or misunderstood information is found to be associated with improved health outcomes compared to communication as usual (Spencer, 2019; Schillinger et al., 2003). Spencer (2019) found that using the teach-back method in diet education led to improved dietary compliance and improved blood pressure control for patients with low health literacy and hypertension. Schillinger et al. (2003) observed primary care physicians in public hospitals educating 74 patients with diabetes mellitus and low health literacy on management concepts to find a significant positive correlation with good glycemic control and the use of a comprehension-check strategy. Teach-back and comprehension checks are built into the SDM model within the option talk stage.

Changing Healthcare Practices

Although continuing educational courses are often lectures, authors have found didactic knowledge-acquisition based meetings are not effective in changing practitioners' behaviors (VanNieuwenborg, Goossens, De Lepeleire, & Schoenmakers, 2016; Fisher et al., 2016; Forsetlund et al., 2009). The best practice in continuing education programs is for the course to be designed for adult learners and focus on changing practitioner knowledge, attitudes, and behaviors (VanNieuwenborg, Goossens, De Lepeleire, & Schoenmakers, 2016; Fisher et al., 2016; Forsetlund et al., 2009). Adult Learning Theory and the most effective formats to change practitioner knowledge, attitudes, and behaviors are discussed below.

Adult Learning Theory

There are six key principles of adult learning (VanNieuwenborg et al., 2016). Adults are results-oriented, self-directed, relevancy-oriented, use life experiences as a basis, practical, and motivated to learn when they think the information can help them solve a problem in their lives or work (VanNieuwenborg et al., 2016). Consequently, adults learn best when they value the material, feeling that it is integral to and realistic within their work context. Additionally, the course should be designed to allow the learners to have room to control their techniques and goals within the material.

Format

A combination of didactic and interactive formats is the most effective in changing professional practice compared to either format alone (Fisher et al., 2016; Forsetlund et al., 2009). Examples of effective interactive formats include peer review, role-play or practice sessions (VanNieuwenborg et al., 2016). Additionally, a series of

sessions has a greater impact on performance change than a single session (VanNieuwenborg et al., 2016). VanNieuwenborg et al. (2016) recommend the first session to be focused on acquisition of knowledge and implementation skills and later sessions to focus on assessment, discussion, questions, and additional practice. Audit and feedback is a common process to assess a practitioner's current performance against standards or outcomes with the goal of improving the performance of a target behavior (Ivers, et al., 2012). Audit and feedback is more effective when practitioner baseline performance is low, it is provided by a supervisor or colleague, it is provided more than once, it is delivered in both verbal and written formats, and includes an action plan to meet explicit targets (Ivers et al., 2012).

Conclusion

In summary, the proposed factors that limit client's opportunity to participate in a collaborative process to select a wheelchair may be minimized with the use of improved verbal and written communication strategies such as using plain language, using the Teach-Back method, and summarizing key points. Engaging clients in the Shared-Decision Making process over several sessions to make the long-term decision of wheelchair selection may increase consumer participation, knowledge of treatment options, and satisfaction, ultimately enhancing participation in mobility-related activities of daily living if the client obtains and uses the selected mobility device especially for disadvantaged groups. When aiming to change healthcare practitioners behaviors, the material should be specific, meaningful, realistic, and applicable to their work, with

clearly stated goals of learning delivered across sessions in a mixed interactive and didactic format.

Part II: Getting There Together Professional Development Course: Shared-Decision Making in Wheelchair Evaluations

Introduction

The proposed program is a professional development course for preparing providers to enact best practice of Shared-Decision Making (SDM) with clients in the wheelchair procurement process. The course will be offered in-person to interprofessional providers involved in wheelchair prescription and procurement. The course content and structure were developed according to a literature review to determine the best practices in SDM and changing healthcare professional behaviors.

Program Description

Program goal

Providers will be confident and effective in enacting best practice SDM in their practice in wheelchair procurement to optimize person-technology fit to promote participation in mobility-related activities of daily living.

Objectives

By the end of the course, participants will be able to:

- Identify and describe the 3 steps of SDM
- Describe 3 resources available to facilitate SDM
- Increase practitioner confidence in use of SDM
- Increase practitioner competence in the use of SDM
- Increase use of SDM in practice

Outcomes

Proximal outcomes include improving knowledge of SDM principles and the implementation of these principles into practice as measured by pre- and post- self-report measures collected at the beginning of each session. Distal outcomes are to increase consumer reports of participation in the decision-making progress and to improve consumer reports of performance in mobility-related activities of daily living.

Recipients

Program participants will include healthcare providers from various disciplines who work with wheelchair-users during the assessment and procurement process. The course is intended for at least 6 participants at a time in order to facilitate collaboration and reflection.

Course format and delivery method

The course will be offered in an in-person format delivered across three two-hour courses over three months at the location of a local partner such as a hospital conference room. The course will be delivered in three parts; as a series of sessions has a greater impact on performance change than a single session (VanNieuwenborg et al., 2016). The modules will be structured based on the recommendations for healthcare practitioners' behavior change (VanNieuwenborg, Goossens, DeLepeleire & Schoenmakers, 2016; Fisher et al., 2016; Forsetlund et al., 2009) and principles of Adult Learning Theory (Knowles, 1980; Knowles, 1984). The course will be delivered by an occupational or physical therapist that has at least two years of practice in wheelchair evaluation and has greater than 80% client-reported use of SDM in their practice.

Key Course Components

The course leverages a combination of (1) didactic information, (2) collaborative application, (3) group and personal reflection, (4) goal setting based on healthcare practitioner behavior change recommendations and the principles of adult learning theory.

Didactic Information.

The course will begin with a reflection of current practices including shortfalls to "care as usual" to emphasize why learning the SDM approach is meaningful to the learners' contexts. This reflection will encourage learners to draw from their experiences, understand the importance and future application of SDM principles, and increase internal motivation in alignment with the principles of Adult Learning Theory (Knowles, 1980; Knowles, 1984). Didactic information will be presented about each of SDM's "three talks" based on the SDM model developed by Elwyn et al. (2017).

Behavior Change: Collaboration & Goal Setting.

The course utilizes a combination of didactic and interactive teaching methods in order to engage learners and facilitate immediate application of new skills and approaches. Examples of learning activities used include:

- Group discussion of participants' experiences including challenges and successes in engaging consumers in decision talk. The facilitator will guide participants through a discussion to explore causal reasons, expand their thinking reflection, and to consider alternative explanations. Reflections will occur at the start of session 1 and 2 in order to reflect on initial application attempts utilized in

practice.

- Course participants will engage in role playing therapeutic encounters in large groups and with partners followed by group discussion and personal reflection on performance strengths and areas of growth thereby exploring diverse viewpoints, perspectives, and suggestions.
- Participants will collaborative to create personal goals to implement SDM in their practice between sessions to be reviewed at the subsequent sessions.
- Participants will create a personal resource binder that summarizes key points from the courses, feedback and self-reflection from role plays, notes from brainstorming, personal goals, and a list of SDM resources. Participants will be able to return to the binder after course completion in order to support the implementation of SDM into practice.

Course Content Outline

Session 1:

1. Collaboration: Review and reflection of care as usual to guide practitioners to consider consumer perspectives and potential long-term outcomes of inadequately prescribed wheelchair equipment
2. Instruction: SDM "Team Talk"
3. Partnership: Role Play of "Team Talk." Partner then group reflection on strengths and challenges. Repeat for "Choice Talk" and "Decision Talk"
4. In context: Action plan/goals for implementation in small groups

Session 2:

1. Instruction: Review Descriptions of Three Talks and Effective Communication
2. Collaboration: Facilitator led group discussion on implementation goals, strengths, challenges, and group problem-solving.
3. Partnership: Applying problem-solving in partner role plays. Partner and group reflection on strengths and challenges with continued problem solving.
4. In context: Action plan/goals for implementation in small groups

Session 3:

1. Collaboration: Facilitator led group discussion on implementation goals, strengths, challenges, and group problem-solving.
2. Instruction: Resources
3. Collaboration: Creation of personal resource guide or "tool kit"
4. In context: Action plan/goals for implementation in small groups

Table 1. Support for Program Design

Delivery	Learning Objective	Learning Activity	Theoretical Background
Collaborative facilitator-led discussion	-Identify 3 short comings of practice as usual	*Session 1:* Review and reflection of care as usual facilitator guiding practitioners to take on consumer perspectives and potential long-term outcomes of inadequately prescribed wheelchair equipment.	-Adult learners are more likely to be motivated to learn when material is important and meaningful to their roles (Knowles, 1980).
Didactic Information and collaboration	-Identify and describe the 3 steps of SDM	*Session 1:* Instruction of the "Three Talks" with immediate opportunity to role play in partners after each talk. *Session 2*: Short review of SDM principles and "Three Talks" and education on clear health care communication *Session 3:*	-VanNieuwenborg et al. (2016) recommend the first session to be focused on acquisition of knowledge and implementation skills. -Learners should have immediate opportunities to apply learning (Knowles, 1984). -A combination of didactic and interactive formats is the most effective in changing professional practice compared to either format alone (Fisher et al., 2016; Forsetlund et al., 2009).
Didactic instruction and collaboration	-Describe 3 resources available to facilitate SDM	*Session 3:* Educator facilitates explains common resources including online tool boxes, academic papers, and community practitioner forums. Participants explore resources and work in small groups to discuss merits of various resources to select personally meaningful ones to create a "tool kit" for future reference.	-Educators should work collaboratively with learners to select resources (Knowles, 1984).
Audit and Feedback and Collaboration	-Increase practitioner confidence	*Session 1:* Reflection between partners and the larger group acts as audit and feedback after roleplay of a "Talk" concept.	-Audit and feedback is more effective when practitioner baseline performance is low, it is

	in use of SDM -Increase practitioner competence in the use of SDM	This provides multiple opportunities for participants to reflect on their current performance compared to the target performance. Feedback will be provided verbally from peers and facilitator. Participants are encouraged to write down 2-3 meaningful pieces of feedback per role play. *Session 2 & 3:* Facilitator led group discussion on implementation goals, strengths, challenges, and group problem-solving.	provided by a supervisor or colleague, it is provided more than once, and it is delivered in both verbal and written formats (Ivers et al., 2012). -Later sessions should focus on assessment, discussion, questions, and additional practice to change practitioner behaviors (VanNieuwenborg et al., 2016)
Collaborative Goal Setting and Self-Guided Learning	-Increase use of SDM in practice	At the conclusion of each session, small groups will collaborate to create specific, realistic, actionable, measurable, and time-constrained goals for the implementation of SDM into their practice. After the course, participants will be sent reflection activities via email every month for 6 months to encourage reflection, questions, and further goal setting.	-Feedback is most effective when it includes an action plan to meet explicit targets (Ivers et al., 2012). - Adults are self-guided in their learning (Knowles, 1980).

Barriers and Challenges for Implementation

The primary barrier in the implementation of this course is the lack of an identified learning interest for wheelchair evaluators to learn about Shared-Decision Making. Marketing efforts that highlight the important impacts of SDM in quality of care and consumer satisfaction may raise interest and the awareness of the need to engage consumers in decision-making. Once interest is established, additional challenges include

gathering enough practitioners within a region to participate in the collaboration-based course. Scheduling demands may influence the course director's ability to find a mutually convenient time for the course. The ability to schedule course times within a month timeframe allows for greater flexibility to meet participants' time demands.

Another challenge to implementation is the workplace culture where practitioners work. A workplace that supports new behaviors and values the participation of consumers in their healthcare treatments and goals may enable easier adaptation of new practitioner behaviors. In contrast, lack of support from supervisors may decrease behavior change. Therefore, the course implements six months of further reflection and guidance to encourage motivation for learning and application to practice.

CHAPTER FOUR: EVALUATION PLAN

Shared-Decision Making (SDM) is recommended as "best practice" across a variety of service settings (Elwyn et al., 2017; Elwyn et al., 2012, O'Connor et al., 2007; Elwyn et al., 2010). Getting There Together (GTT): Shared-Decision Making (SDM) in Wheelchair Evaluations is a continuing education course consisting of three 75-minute sessions designed to teach healthcare clinicians how to effectively engage and collaborate with consumers in selecting wheelchairs.

The course will be offered to interprofessional practitioners working in the wheelchair procurement process. The course content is based on the findings of a literature review examining the best practice in treatment decision making, effective SDM, and communication of health information. Guided by principles of adult learning and recommended strategies for changing healthcare practitioner behaviors, the course will utilize a multi-method approach to teach content, facilitate immediate implementation of learning to practice, collaboration, and goal setting.

Purpose of Proposed Program Evaluation

While there is evidence of the benefits of SDM in diverse medical settings including, but not limited, to primary care, oncology, and psychiatry, the efficacy of SDM within wheelchair procurement has not been studied (Joseph-Williams, Elwyn & Edwards, 2013; Joosten et al., 2008). Therefore, the evaluation plan for GTT is designed to provide information for future program development and growth. The phases of program evaluation are described below: an evaluability assessment and a course evaluation. The first section describes the evaluability assessment, which is used to

inform course development through feedback from the digital focus group with the key stakeholders. The following section describes the phases that make up the course evaluation, which is used to determine if the course caused a change in the participants' perceived confidence, competence, and integration of SDM into practice.

Evaluability Assessment: Course Design

The evaluability assessment will provide recommendations on how the initial proposed course can be improved prior to implementation. The evaluability assessment will include a focus group with a diverse set of key stakeholders to understand their various perspectives on wheelchair procurement and continuing education. The focus group will meet digitally using on online video conferencing platform to increase accessibility for stakeholders. The information gathered will be used to adjust course content and structure, and strengthen feasibility of the course to meet the needs of the stakeholders. Once the course content and format are finalized, a preliminary course evaluation will be conducted to examine if the course is effective in meeting its target outcomes (Phases 2-5). See table 3 for details of each evaluation phase.

Evaluation Questions

Evaluation questions were developed with consideration for the unique needs of the courses' future stakeholders including the consumer, the practitioners, administrators, insurance companies, continuing education distributers, and the course developer. See Table 2 for the interest that each stakeholder group has in the course and the program evaluation questions.

Course Evaluation: Measuring Outcomes

After the evaluability assessment (Phase 1) is completed, the course evaluation will occur across four phases to evaluate the participants' perceived confidence, competence, and integration of SDM into practice. These outcomes will be assessed before, during, and after the course (Phases 2-5).

Table 2. Key Stakeholder Focus Group

Key stakeholder groups	Potential interest in the course	Questions to be asked in the program evaluation
Consumers	Increase or improve performance in mobility-related activities of daily living (MR-ADLs) Receive best practice in care, addressing family needs Be an active participant in the wheelchair selection process	- Please describe your experiences in the wheelchair evaluation process. • What went well? • What did not go well? - How did the recommended equipment impact your activities of daily living? - How would you like practitioners to approach the wheelchair evaluation process?
Practitioners	Provide best practice, i.e. SDM to increase consumer-AT fit and satisfaction	- Describe your current perspective on wheelchair evaluations. - How do you conduct wheelchair evaluations? • What is working? • What is not working? - What are the facilitators and barriers during the wheelchair evaluation process?

Scope and Data Collection

All course participants (approximately 6-20 interprofessional healthcare practitioners involved in the wheelchair procurement process) will complete the course evaluation measures at four points in time. All evaluation data will be collected through

online questionnaires that support participant anonymity. See Table 3 for a description of data collection for each of the five phases.

Table 3. Evaluation Phases.

	Time	**Data collected**
Phase 1	Prior to course start (to inform the development of course content and instructional methods)	-Evaluability assessment – digital focus groups -Focus group with key stakeholder representatives in order to establish course content structure and ecological validity -Pre-launch survey of a group of potential course participants to learn about their specific professional backgrounds, needs, wants, preferred learning styles, and main SDM challenges
Phase 2	Pre-Course	- Pretest questionnaire administered to course participants to determine baseline knowledge of SDM principles and ratings of self-perceived competence, confidence, and integration of SDM into practice
Phase 3	Throughout Course	- Questionnaire administered to course participants at the end of each session to assess learner comprehension of course content and ratings of self-perceived competence, confidence, and integration of SDM into practice -Self-evaluation by each participant of his or her implementation of SDM practice at the end of each session
Phase 4	Post-Course	-Post participation course evaluation questionnaire -Individual interviews with random sample of participants
Phase 5	3–6 months after course end	- Long-term summative study of participant and client outcomes (Including: change in SDM implementation; client satisfaction; client outcomes). The data will be collected using of interviews, trained observations, and emailed questionnaires to practitioners and consumers.

The proximal outcomes to be measured include course participants' knowledge of SDM principles, self-perceived confidence and competence in the utilization of SDM, and setting goals for consistent implementation of SDM into practice. These outcomes will be measured through self-report questionnaires completed by participants prior to

course start (pre-test) and following the course completion (post-tests) at the conclusion of session 3, and then again 3 and 6-months after completion of the course. The distal outcomes are to increase practitioners' self-reported use of SDM used with clients and attainment of practitioners' implementation goals. At 6-months after course completion, participants will be invited to provide feedback via a semi-structured phone interview to elicit the participants' perspective of the course's value, content and structure, efficacy in teaching SDM and impact on changing practitioner behavior.

Course Evaluation Design and Methods

The program evaluation utilizes qualitative and quantitative methods. Table 3, above, describes the approach for each data collection strategy. Overall, the design is a pretest-posttest methodology using questionnaires to measure changes in target outcomes. The participants act as their own controls as there is no comparison group.

Data Management Plan

The data will be collected anonymously with no personal identifiers linked between responses and the participants through the use of an online survey platform. In order to track pre- and post- test outcomes, participants will choose unique 3-digit number identifiers to represent their input. This identification process will allow for de-identified information to be collected while being able to measure change in target outcomes over time. The data will be organized electronically on the evaluator's password-protected computer in a password-protected spreadsheet. All data will be stored virtually in a cloud system and password-protected flash drive saved after each phase of data collection.

Data Analysis and Reporting

Integration and analysis of the data gathered from the evaluability assessment and course evaluation is needed to demonstrate the value and impact of the GTT program. Upon establishing the value of the course, the evaluation data can be used to convince key stakeholders such as practitioners, employers, and organizations to invest time and money in the course. The data will also be used to revise the course content and structure to better meet the intended goals of the course.

Due to the nature of mixed methods and large amount of data collection, the primary investigator will utilize professional statistical and qualitative coding assistance. A data analyst will be hired prior to data collection to consult on the best statistical analyses for the data sets. The qualitative data will be transcribed and will be analyzed for content that may code into themes. The data from phase one will be analyzed and synthesized to market the course to practitioners. The quantitative data from phases two through five will be analyzed to determine course efficacy and to guide the continued development of the course to better meet the ultimate goal of increased participant self-perceived competence, confidence, and integration of SDM into practice.

CHAPTER FIVE: FUNDING PLAN

Summary

Getting There Together: Shared Decision Making in Wheelchair Evaluations (GTT) is a professional development course designed to educate providers about how to engage clients in the Shared-Decision Making (SDM) process during wheelchair prescription and procurement. This in-person course will be offered to inter-professional healthcare providers involved in wheelchair prescription and procurement. The course content and structure were developed based upon advantageous findings within the literature regarding best practices in SDM and how to foster changes in healthcare professionals' behaviors. The resources below are projected to cover the cost for this course to run for two years including the expenses for both the creation phase and the implementation phase of this program.

Creation Phase

The first expenses relate to the cost of the creation of this educational program. In the first year especially, using available and donated resources lowers the funding barrier thereby improving the likelihood of the GTT program's creation and implementation. See table 5.1 for list of available resources and justifications.

The program developer is an occupational therapist who will be responsible for program creation and implementation. The program developer is able to take up to 5% voluntary time off from her full-time position and maintain her benefits. The program developer will have decreased yearly salaries as a result of her reduced work hours that are considered a donation to the program. Ideally, this expense will be able to be

recuperated in later years once the course is better established and can generate higher revenues.

The program developer's husband has volunteered his services in business planning, operations, strategy and financial modelling. His experience as a consultant for several start-ups and start-up creator will guide GTT to grow in its first year while saving on consultation expenses for GTT's general business and accounting needs.

The program developer already has access to the Microsoft Office Suite, an expense otherwise costing $98.99, which allows for the creation of high-quality materials at home. The program developer has extended experience using Canva, a free online basic graphic design template, that can be used to make high-quality marketing materials to distribute via social media, emails, and to print physical copies.

Despite the donated time and preowned resources, there will be additional expenses in order to best complete the development of the course. See Table 5.2 for comprehensive estimated expenses and revenue. In order market the course, brochures will need to be printed. These brochures will be complimentary to the online marketing efforts distributed through the developer's network. At Costco, printing 250 brochures will cost $99.99. The program developer has chosen to distribute marketing materials in-person to local hospitals and out-patient centers in the Northern California area. While hand-delivery may be a more expensive and time consuming, the developer believes it will increase the likelihood of reaching her target audience and build rapport with relevant stakeholders in the community. The program developer will utilize her personal vehicle to deliver them, which will cost an estimated $50 in gasoline and $21 in bridge

toll expenses.

The final step of the course-creation phase is to apply for an Approved Provider Program (APP) Single Course Approval through AOTA, a one-time cost of $275 for a Tier 1 program which covers up to nine events per year. GTT aims to host two events in its first year and five in its second year, qualifying it as a Tier 1 program.

Table 5.1: Available Resources

Category	**Resource**	**Justification**
Salary	Donation of therapist's time	The program facilitator will need to take time off for the creation of the program. She is able to take up to 5% voluntary time off. This will only be during the creation phase. Upon implementation, facilitator will begin receiving a salary.
	Donation of therapist's husbands time	Facilitator's husband will donate time to consult on GTT as a business in growth, strategy, and financial planning.
Supplies	Microsoft Office Suite	Owned by program creator. Used to create booklets, worksheets, and pen and paper assessments.
	Printer	Owned by program creator. Used to print assessment materials.
	Personal vehicle- owned	Owned by program creator. Used to hand-deliver brochures to Bay Area hospitals. In-person delivery will improve rapport with interested stakeholders and improve likelihood the materials will be displayed.
	Computer-owned	Owned by program creator. Used to create digital materials and complete digital correspondence and marketing.
	Canva	Free digital resource. Used to create brochures and design high-quality marketing materials.
	HDMI cord	Owned by program creator. Used to project digital materials to screen for presentations.
	Internet	Owned by program creator. Used for online marketing, applications, creation of materials using online resources, emailing, and other administrative needs.
Other	Physical room	As an in-person course, a physical room with projector is required to present the material. There are multiple hospital community spaces available for free rental when rented for educational workshops, and the worksite of this

		therapist has volunteered their community meeting space and projector to host a course. https://arts.stanford.edu/for-students/arts-spaces/arrillaga-multipurpose-room/

Implementation Phase

Once the course is operating, the program developer will also act as the program facilitator for the courses and will begin receiving a salary. Based on the Bureau of Labor Statistics (2020), career continuing education teachers are paid an average of approximately $30 per hour. In the first year, the program is projected to run two courses. The facilitator will allocate five hours per course in order to accommodate set-up, teaching, and clean-up before and after the course. In the second year, the goal is to host 5 courses. Consequently, the program facilitator's first year salary will be $300 and the second-year salary will be $750. As a result, $1,050 must be budgeted for the program facilitator's salary for these two years.

Large scale printing for the education materials and course assessments are needed. Each course will require printed comb-bound workbooks for each participant totaling 8-10. At Office Depot, each comb-bound book is estimated to cost $4.50, which can vary depending on length of the workbook. GTT conservatively budgeted $100 for the first year to account for a total of 20 comb-bound booklets, 10 per course, and a $10 margin in case the price of booklets increased. GTT conservatively budgeted $250 for a total of 50 comb-bound booklets, 10 per course, and a $25 margin to accommodate inflation in printing costs.

Additionally, GTT plans to have printed paper and pencil course assessments as part of its evaluation. The program facilitator will use her personal printer to print the course evaluations. Therefore, GTT budgeted $68.63 to purchase ink, which costs for, $45.99, and paper, which costs, $22.64. This expense is budgeted each year due to the consumable nature of the supplies.

As an in-person course, GTT requires a physical location. Fortunately, there are multiple hospitals with community rooms available for free rental when rented for educational workshops. Additionally, the program facilitator's workplace has donated access to their owned multiple locations. All rooms discussed include access to projection equipment for presentations, internet, tables, and chairs.

Revenue

The course will garner its revenue through participant registration fees. The course will cost $30, which is a relatively low price in comparison to courses of similar length on AOTA CEU course catalogue. Competitive pricing is vital in GTT's first two years, in order to encourage practitioners to register. To run effectively, the course requires at least 6 participations to allow for collaboration and conversation. Based on the goals for number of courses in each year, GTT aims to make $360 in its first year and $900 in its second year. The revenue made will be reinvested in the course. See Table 5.2 for revenue and its impact on total anticipated budget.

Table 5.2: Expenses and Revenue

Budgeted Item	**Year 1**	**Year 2**	**Justification**
Salary	$30/hour Calculation: $30*5 hrs*2 courses = $300	$30/hour Calculation: $30*5 hrs*5 courses = $750	During the implementation phase, therapist will be paid the average amount for career continuing education teachers based on the average figure from the Bureau of Labor Statistics. www.bls.gov
	Total: $300	*Total: $750*	
Supplies	Gasoline: $50	Gasoline: $50	Gasoline in San Francisco is currently priced at $2.90 per gallon. The program facilitator's car yields 36 miles per gallon. $50 will allow for commuting approximately 600 miles to distribute brochure materials in-person to local facilities to build rapport.
	Toll Bridges: $21	Toll Bridges: $21	Tolls for the Bay Bridge ($7), Richmond Bridge ($6), and Golden Gate Bridge ($8) www.bayareafastrak.org/
	HP Ink: $45.99	HP Ink: $45.99	Pack of color and black ink for printing evaluation assessment single pages as needed to determine course efficacy and growth areas. store.hp.com/
	Box of 60 pens: $5	Box of 60 pens: $5	Box of 60 pencils for each year to complete pen-and-paper assessments and to provide to participants during the course. www.staples.com
	Total: $121.99	*Total: $121.99*	
Materials	Dissemination brochure: $99.99 for 250 brochures	Dissemination brochure: $99.99 for 250 brochures	Every year, brochures will be needed to advertise the course. www.costcobusinessprinting.com/brochures
	Bound booklets for the course: $100 Calculation:	Bound booklets for the course: $250 Calculation:	To facilitate learning and disseminate information booklets allow for a centralized location for presented information, notes, and reflection pages. www.officedepot.com

	$4.50*10 booklets*2 courses+$10 margin	$4.50*10 booklets*5 courses+$25 margin	
	Single page for assessment and evaluation plan: 5 reams of paper: $22.64	Single page for assessment and evaluation plan: 5 reams of paper: $22.64	5 reams of paper available for printing course assessment and evaluation plan documents available from Staples to determine course efficacy and areas for development. www.staples.com
	Total: $221.63	*Total: $221.63*	
Other	Application for Approved-Provider-Program Single Course Approval through AOTA: $275	N/A	In order for therapists to gain continuing education hours to go towards license renewal it must be an AOTA APP. As a course with less than 9 yearly events it qualifies as a Tier 1 program. www.aota.org/
	Total $275	N/A	
Revenue	Registration Revenue: $360 Calculation: $30*6 participants * 2 courses = $360	Registration Revenue: $900 Calculation: $30*6 participants * 5 courses = $900	For a 4.5-hour course, $30 is a competitive price. Competitive pricing is important to garner participants for a new course. Pricing based on AOTA CEU online catalogue. http://learn.aota.org/diweb/catalog
	Total: $360	*Total: $900*	
Total Expenses	*$919.62*	*$1244.62*	
Total	$559.62	$344.62	Calculated based on expenses minus estimated revenue.

Potential Funding Sources

While self-funding the creation and implementation of GTT is an option, there are external funding sources such as grants that the program facilitator can apply for. GTT meets the criteria for three potential grants (see *Table 5.3* for details). The first grant is operated by the California Foundation for Occupational Therapy. GTT is a strong applicant for the seed money of this grant because it seeks newly created occupational therapy programs that will be beneficial for the consumers. The California State Council on Development Disabilities Council is also a strong match for GTT as the program's goal is to improve healthcare systems in order to benefit consumers and family members in California. Lastly, the Student Research Grant offered through the program facilitator's university is potential grant since GTT aligns with the grant's goal to create significant improvements in clinical practice through training to make lasting effects on consumer outcomes.

Table 5.3: Grants

Grant information	**Criteria for grant that makes it applicable**
California Foundation for Occupational Therapy: Program Development Project Seeds Money Maximum award: $250	• For OT practitioners interested in developing a new intervention or education program for public benefit. • Intended to fund OT practitioners for items such as equipment, consultations fees, printing, postage, and supplies for the development of programs that address OT practice. https://www.cfot.org/research/
California State Council on Development Disabilities Council: Program Development Grants	• Funding for new approaches to serving Californians with developmental disabilities that are part of a strategy for systemic change. • For events/programs that will increase ability of consumers and family members to exercise control, choice and flexibility in the services and supports they receive

Maximum award: $1500	https://scdd.ca.gov/grantinformation/
Sargent College: Student Research Grant Maximum award: $2500 with 50% match by mentor	• For students and postdoctoral fellows working with Sargent-primary faculty • Based on potential significant clinical impact and training value http://www.bu.edu/sargent/research/research-funding-administration/funding-opportunities-for-sargent-faculty-and-students/student-research-grant/

Conclusion

Overall, GTT has a relatively inexpensive budget which is an advantage when applying for grants because even a small grant can cover the funds required for this program. This achievable budget was made possible due to the program developer and her husband's volunteered time, efforts, and resources, which, increases the feasibility of the program's creation and implementation.

CHAPTER SIX: DISSEMINATION PLAN

Overview of the Program

Getting There Together (GTT): Shared-Decision Making in Wheelchair Evaluations is a continuing education course designed for healthcare practitioners to address the inequity of wheelchair evaluation accessibility experienced by consumers. GTT's curriculum was specifically designed using best, evidenced-based practices for teaching and facilitating practitioner behavior change in order to improve shared-decision making as it applies to the personal and complicated process of wheelchair prescription. The course combines didactic and collaborative learning to support practitioners in their use of clinical best practices in order to ultimately improve consumer satisfaction, wheelchair-person fit, and participation in mobility-related activities of daily living. This dissemination plan was designed to effectively communicate information about GTT, its importance, and how to participate in order to achieve this long-term goal.

Dissemination Goals

Before GTT has the ability to impact consumer health outcomes, it needs to achieve short-term goals. *Table 6.1* outlines the short-term and long-term goals that mark successful dissemination. The short-term goals focus on successful connection with key sources that will distribute information to target audiences and the acquisition of course participants. Connection with key sources is operationalized as at least 10 in-person meetings with directors in both adult and pediatric settings. Successful registration is operationalized as having at least six participants registered for the course.

The long-term goals shift the focus to the sustainability of this course and the

achievement of the course's objectives. Sustainability is operationalized in two one-year goals focused on the number of times the course is conducted in each of its first two years. The goal is to have two and then five in the respective years. The course objectives include increasing practitioner competence and confidence in their ability to implement shared-decision making (SDM) and facilitating its regular use into their practices. The last long-term goal is to facilitate the long-term tracking of health outcomes when using SDM that will allow for future advocacy of the course and practice of SDM.

Table 6.1 Goals of Dissemination

Short-Term Goals
The Getting There Together (GTT) Program will be disseminated to at least ten adult rehabilitation supervisors in the Bay Area including hospitals or clinics that prescribe wheelchairs in-person by course creator.
The GTT Program will be disseminated to at least ten pediatric rehabilitation supervisors in the Bay Area including hospitals or clinics that prescribe wheelchairs in-person by course creator.
The GTT Program will have at least six registered participants for its first session within three months of the initial dissemination.
Long-Term Goals
The GTT Program will be an established course that meets twice within one year of the initial dissemination.
The GTT Program will be an established course that meets five times in the second year of the initial dissemination.
GTT course participants will report increased confidence in their ability to implement shared-decision making in their practice by the end of the course as measured by end-of-course self-reported perceptions on course evaluations.
GTT course participants will report using shared-decision making in their practice within six months of taking the course as measured by self-reported perceptions in 6-month follow-up course evaluations.
GTT course participants implement regular use of established measures, such as the COPM-5, to measure and track change of performance and satisfaction in mobility-related activities of daily living within six months from their completion of the course as measured by self-reported use in 6-month follow-up course evaluations.

Target Audiences

In order to effectively reach the short-term and long-term goals, it is important to focus dissemination efforts to reach interested target audiences. The two primary audiences consist of occupational and physical therapists that conduct wheelchair evaluations in adult and pediatric settings. These settings are considered distinct based on the organizational systems of hospitals and clinics that have pediatric and adult settings operate independently with distinct supervisors and directions. These therapists are considered the primary audience because they are the ones that will register for the course to determine if the GTT's short-term and long-term goals of running regularly with at least six participants will be met or not.

The secondary audience consistent of the larger administration team at hospitals and clinics. As administration makes decisions about hosting continuing education and encouraging participation in specific trainings, they will be an important audience to facilitate the further dissemination to their therapists.

Key Messages

In order to disseminate the course's content effectively, the target audiences must understand GTT's importance and call to action. Key messages have been crafted that highlight how GTT meets the respective interests and values of the primary and secondary audiences. *Table 6.2* displays these messages. For example, therapists value providing high-quality, evidenced-based practice that improves health outcomes. Additionally, money and time constraints are factors that impact a therapist's choice when deciding what continuing education course he or she will take. Therefore, the key

message for therapists highlights how GTT is short and affordable course designed using evidence of best practices to improve consumer satisfaction, self-efficacy, knowledge, and adherence to treatment. Lastly, the message communicates a clear call to action to register for the class. In slight contrast, the key message for administration highlights patient satisfaction and money saved as these are commonly tracked key performance indicators used in hospitals and clinics. Administrators are called to have all evaluating therapists participate in the course and given the task to register for hosting the course in their facility. In addition to the content of these key messages, the reception is dependent on who delivers them.

Table 6.2 Audience, Messages, and Sources

Primary Audiences	**Key Messages**	**Messaging Sources**
Pediatric wheelchair evaluators including occupational and physical therapists	Getting There Together (GTT) is a short and affordable course designed using evidence-based practice and best teaching practices to improve therapists' confidence and competence in implementing Shared-Decision Making (SDM) during wheelchair evaluations. Using SDM is shown to improve consumer self-efficacy, satisfaction, knowledge of options, and adherence to treatment. Register for GTT today to provide the best quality care for your families.	1. The course developer will meet in-person with other rehabilitation directors and supervisors from Bay Area hospitals and clinics including but not limited to Kaiser, Stanford Healthcare, Dignity Healthcare, UCSF, SF General Hospital. This will enable the directors to become messengers to their therapists that fit the target primary audience. 2. Supervising occupational therapist at San Mateo California Children's Services-Medical Therapy Unit (CCS-MTU), which piloted the Whole-Child Model now used across CCS-MTUs. Established pediatric OT with over 20 years of experience in California with connections to other major health organizations. CCS is one of the primary funding source for pediatric wheelchairs in California. Course

		creator has a personal relationship with this person.
Adult wheelchair evaluators including occupational and physical therapists	Getting There Together (GTT) is a short and affordable course designed using evidence-based practice and best teaching practices to improve therapists' confidence and competence in implementing Shared-Decision Making (SDM) during wheelchair evaluations. Using SDM is shown to improve consumer self-efficacy, satisfaction, knowledge of options, and adherence to treatment. Register for GTT today to provide the best quality care for your clients.	1. The course developer will meet in-person with other rehabilitation directors and supervisors from Bay Area hospitals and clinics including but not limited to Kaiser, Stanford Healthcare, Dignity Healthcare, UCSF, SF General Hospital. This will enable the directors to become messengers to their therapists that fit the target primary audience. 2. Clinical specialist and occupational therapist at Stanford Neuroscience Health Center that leads the clinic's wheelchair evaluation program. She has practiced at Stanford for over 20 years and is a trusted provider with professional connections across settings. Course creator has a personal relationship with this person.
Secondary Audiences	**Key Messages**	**Messaging Source**
Hospital and Clinic Administrators	Shared-decision making is the golden standard for wheelchair evaluations as it leads to improve consumer satisfaction, less device abandonment, and improved participation in mobility-related activities of daily living. Getting There Together (GTT) is a short affordable course designed to improve therapists' confidence, knowledge, and implementation of Shared-Decision Making during the wheelchair evaluation process. All evaluating therapists should participate in the GTT course as it will reduce costs from	Rehabilitation directors will continue to be the primary messengers to disseminate key messages upwards to hospital clinics and administrators. This aligns with their existing roles as ambassadors or representatives of their rehabilitation specialties, which will increase the likelihood that the information is well received.

	abandoned equipment while improving the quality of care, and consumer satisfaction. Register today to host a GTT course for the therapists in your hospital or clinic.	

Messenger Sources

Rehabilitation directors will be the primary sources to disseminate key messages to the primary and secondary audiences. Rehabilitation directors occupy a unique position as they can disseminate information to those they supervise and to hospital and clinic administrators. The role of rehabilitation directors is to act as trusted leaders of their therapy team while acting as a representative to hospital and clinic administration. Therefore, the creator of the course will arrange in-person meetings with clinic and hospital rehabilitation directors to share key messages to enable them to reach the aforementioned target audiences. The program creator will meet with directors and supervisors in pediatric and adult settings from various clinics within the Kaiser, Stanford Healthcare, Dignity Healthcare, UCSF, Golden Gate Regional Center, Regional Center of the East Bay, and SF General Hospital networks in order to spread this course across the Bay Area providers. The course creator will provide brochures and digital flyers to support their ability to effectively disseminate the information to their respective audiences.

In addition to the broad category, specific directors and supervisors have been identified (*Table 6.2)* that the program creator has personal relationships with. Their ability to successfully disseminate the course is enhanced because they are more

motivated to support the creator and their established respected standings at their institutions.

In conclusion, GTT intends to rely on proven leaders in order to ensure that the audiences hear from personnel that are considered established, trusted, reliable, and competent to clearly understand and communicate the key messages.

Dissemination Activities

In order to communicate the course's offerings and information clearly, electronic and hard copies of the flyers will be provided to the messengers. The course creator will meet with each of the messenger sources to describe the course in greater detail to ensure their understanding of the course, its importance, and its application to their particular setting. Ideally, this meeting will be at least 30 minutes. At the end of the in-person meeting, the course creator will provide paper and digital flyers that the messenger source can use to communicate and advertise to their employees which are the target audiences.

Budget

As discussed previously in Chapter 5, the budget is composed of available resources and items that will be purchased in order to execute the dissemination activities (see *Table 5.1* and *Table 5.2* for detailed line items). Available resources include, but are not limited to, donated time from the course creator to travel and meet with messaging sources, laptop, Wi-Fi, and various software needed to create digital materials. Expenses include, but are not limited to, printing costs for flyers, gas, and toll roads. Overall, these items total $341.98. This a relatively inexpensive cost and achievable for the program.

Evaluation

In order to determine the efficacy of the key messages reaching its targeted audiences, the dissemination plan will be evaluated. The call to action across the key messages is to register for the GTT course. Therefore, the dissemination plan's efficacy will be measured by the number of registered participants. Dissemination will be considered successful if there are at least six participants registered for the course within two months. If there are less than six, the dissemination plan will be considered unsuccessful and will be revised to better meet the short-term and long-term goals.

Conclusion

Getting There Together provides valuable information and support to effectively improve practitioners' confidence and competence in implementation of shared-decision making into their wheelchair evaluations. Consumers will benefit from the knowledge and skills that the occupational and physical therapists gain from the GTT course. In order for the value of this course to be realized it must be effectively disseminated to identified target audiences. Successful dissemination can be achieved for a relatively modest budget and the donation of the creator's time to complete dissemination activities.

APPENDIX A: EXECUTIVE SUMMARY

Introduction to the Problem

There are 29.325 million Americans use wheelchairs as one of their methods of mobility (Brumbaugh, 2018). When appropriately prescribed, wheelchairs can improve consumers' independence, autonomy, and participation in mobility-related activities of daily living (MRADLs). However, prescribing occupational and physical therapists face challenges such as consumers' dissatisfaction, unsuitable wheelchair fit, and abandonment of devices. Although difficult to measure, Cushman & Scherer (1998) have found up to 30% of wheelchairs are abandoned.

It has been long established that lack of consideration for user's opinions can lead to the abandonment of assistive technology (Lenker et al., 2012; Phillips & Zhao, 1993) In fact, Martin et al. (2011) reported that consumers that felt that their personal needs were not assessed also reported lower satisfaction with their AT devices. Nearly of third (31.3%) of consumers that reported feeling uninformed stated that lack of assessment of their needs as a factor contributing to their dissatisfaction (Martin et al., 2011). Despite this knowledge, consumers continue to report limited participation in the evaluation process (Lenker et al., 2012).

The American Association of Occupational Therapy (AOTA) Code of Ethics states that one of the profession's core values is patient autonomy, which includes a person's right to make treatment choices based on his or her values and beliefs (AOTA, 2015). Despite this core value of occupational therapy, researchers continue to document consumer reports of limited participation in the selection wheelchairs and continue to

recommend increased consumer involvement.

Consumers are reporting dissatisfaction, limited information, and lack of participation in the wheelchair evaluation process that results in long-term negative impacts on participation in MRADLs. To address this problem, a continuing education course for wheelchair evaluating practitioners was created called Getting There Together. The course integrates evidence of best practice in healthcare practices, wheelchair prescription, education, and behavior change to improve practitioner confidence and competence in wheelchair evaluation.

Key Findings: An Inaccessible Process

Understanding the factors involved in the process of wheelchair evaluations is key to understanding why consumer participation continues to be limited throughout this process. Increasing the accessibility of the selection of wheeled mobility devices can be addressed using a tiered approach at the individual, organizational, and systems levels (Child & Family Research Partnership, 2018). For the purpose of this review, the focus is on individual and organizational level changes as these factors are more easily modifiable. The following will examine how five individual and organizational factors impact accessibility, in turn, leading to decreased involvement in the wheelchair evaluation process.

Choice Overload

There are more customizable wheelchair and technological options than ever before leading to improved ability to optimize person-technology fit. Service providers and consumers alike have identified increased technology options as a barrier to accurate

wheelchair prescription (Lenker et al., 2012). Having too many options to choose from can result in decreased consumer motivation to make a decision and increased dissatisfaction (Iyengar & Lepper, 2000). While increased choice may lead to improved optimization, it may also contribute to consumers feeling that the process of deciding is too complicated leading to reduced participation.

Low Health Literacy

The National Assessment of Adult Literacy, conducted by the U.S. Department of Health and Human Services (2008) reported that ninety million Americans have limited health literacy. Poor literacy skills are a strong predictor of poor health outcomes (Weiss, 2003). People with low literacy can struggle with their, "ability to read and process information…[and] may give up quickly," (Office of Disease Prevention and Health Promotion, 2018, n.p.). Therefore, when verbal or written information in the wheelchair process does not match consumers' literacy it may result in decreased understanding and decreased participation in the process as they feel discouraged.

Lack of Awareness of Options

Awareness of options relies on the practitioner to know appropriate wheelchair options and to effectively communicate them to consumers, therefore is an extension of choice overload and health literacy. This means that lack of awareness can occur on both the practitioner-level and the consumer-level. Practitioners may not be aware of appropriate wheelchair options, which leads to an omission in its consideration (Greer et al., 2012). Practitioners sometimes omit or ineffectively inform consumers about the various wheelchair options leading to a consumer-level lack of awareness. Without all of

the pertinent information, participation in effective decision making is not possible.

Mismatched AT/Person Fit

Practitioners must understand a consumer's beliefs, perceptions, and values to ensure wheelchair adoption and continued use. Shinohara and Wobbrock (2016) noted that abandonment of AT and willingness to adopt AT is related to the individual's self-concept about using the AT and this self-concept may in turn influence consumers' perception of the usefulness of the recommended AT. Wheelchairs have the potential to increase self-confidence or increase self-consciousness (Mortenson & Miller, 2008). When not addressed and assessed clearly by practitioners, consumers' can negatively impact a consumer's emotional relationship to adaptive mobility equipment leading to disengagement with the process.

Inappropriate Assessment

A systematic review of the ten models of wheelchair evaluation process determined three key elements that are vital during a wheelchair evaluation including evaluating consumer goals, physical/cognitive/functional abilities, and one's environment (Greer et al., 2012). Despite this recommendation, nearly a third (31.3%) of consumers stated their dissatisfaction and feelings of being uninformed were due to a lack of assessment of their needs (Martin et al., 2011). Even when implementing care as outlined by providers, payers, and researchers, wheelchair evaluation is not appropriately assessing consumers' needs.

In summary, occupational and physical therapists aim to empower consumers' choices and autonomy, but to do so they must reduce their individual and organizational

barriers to become more client-centered during the wheelchair decision-making process. Getting There Together is a continuing education course that educates healthcare practitioners about the importance of shared-decision making during the wheelchair evaluation process by improving practitioner's confidence and competence in order to improve consumer participation, satisfaction, and adaptation of wheeled mobility.

The Proposed Solution

Evidence Informing Solution

In order to improve accessibility, increase consumer involvement, and ultimately decrease wheelchair abandonment, practitioners need to change their assessment strategy. Shared-Decision Making (SDM) is a model for clients and clinicians to share the responsibility of medical and treatment decisions based on evidence-based practice (Elwyn et al., 2017). SDM has become a gold standard in U.S. healthcare as it has been used to improve consumers' self-reports of satisfaction in psychiatry, oncology, dentistry, internal medicine, cardiology, community care, neurology, pulmonary, endocrinology, surgery, gerontology and primary care (Joseph-Williams et al., 2013; Joosten et al., 2008).

When applied across medical settings, SDM has been found to have positive health outcomes especially for people from disadvantaged backgrounds that are most likely to experience health inequalities (Durand et al., 2014). In Duran and colleagues' (2014) meta-analysis, disadvantaged groups were defined as people who have low socioeconomic status, low education/literacy level, from geographically underserved locations, and/or are members of an ethnic minority group. SDM interventions

significantly increased participation in decision-making, increased one's knowledge of treatment options, reduced disagreements, increased consumer satisfaction, and adherence to treatment in disadvantaged populations (Durand et al., 2014; Shay & Lafata, 2015; Wyatt et al., 2015). Overall, SDM is an effective assessment strategy to empower disadvantaged populations by increasing accessibility of the process by allowing constructive communication of complex health information and collaboration between consumers and practitioners.

Getting There Together: Continuing Education Course

Getting There Together is an in-person, three-part continuing education course delivered over three months in two-hour sessions for practitioners involved in the wheelchair evaluation process focused on the implementation of shared-decision making. The course format, material, and delivery are based on advantageous findings from a review of the literature regarding how to change behaviors and approaches of healthcare practitioners.

In alignment with best practices, Getting There Together is a continuing education course for healthcare practitioners focused on changing practitioner knowledge, attitudes and behaviors using Adult Learning Theory (VanNieuwenborg et al., 2016; Fisher et al., 2016; Forsetlund et al., 2009). A combination of didactic and interactive formats is the most effective method in changing professional practices compared to either format alone (Fisher et al., 2016; Forsetlund et al., 2009). Therefore, the course utilizes a combination of (1) didactic information, (2) collaborative application, (3) group and personal reflection, and (4) goal setting. The target proximal outcomes of the course are to

improve knowledge of SDM principles and the implementation of these principles into practice as measured by pre- and post- self-report measures collected over time.

The course leverages volunteered time from the course developer and available resources to maintain a relatively low cost for implementation. In the first two years, expenses for the courses' dissemination and implementation total $2,165. The course will be competitively priced to encourage enrollment from practitioners but has the potential to be revenue generating in the future. The course creator has identified three appropriate grants that would be able to cover the expenses.

Conclusion

Getting There Together is a course designed to effectively improve practitioner implementation of SDM into the wheelchair evaluation process. The implementation of SDM improves consumers' ability to access the complex wheelchair evaluation process while considering individuals that are at a high risk for healthcare disparities due to low health literacy and high decisional conflict. Overall, this course has the potential to decrease wheelchair abandonment, increase consumer satisfaction, and improve quality of service delivery.

APPENDIX B: FACT SHEET

Getting There Together: A Professional Development Course for Shared-Decision Making in Wheelchair Evaluations

Emily D'Agostino, MSOT, OTR/L
OTD Candidate

The Problem

- Over 29 million Americans use wheelchairs as one of their methods of mobility[1]
- 10% of wheelchairs are abandoned within 3-months of prescription [2]
- Consumers report limited participation in the wheelchair evaluation process [3]
- Inappropriate wheelchair prescription can limit participation in Mobility-Related Activities of Daily Living [4]

Five Contributing Factors to the Problem

1. Choice overload: Increased options are correlated with decreased consumer motivation to make decisions and increased dissatisfaction [5]
2. Low consumer health literacy: Approximately 90 million Americans have limited health literacy [6]
    - Consumers with low health literacy have decreased reading and processing skills that often limits participation [6]
3. Lack of awareness of options: Practitioners may omit consideration of all the options due to lack of knowledge of various wheelchair features and choice [7]
4. Mismatched Assistive Technology/Person Fit: Consumers' beliefs, values, and perceptions are key determinants in abandonment or adaptation of assistive technology [8]
5. Inappropriate Assessment: 31% of consumers stated that they were dissatisfied-with their wheelchair evaluations due to the lack of assessment of their needs [9]

The Solution: A Continuing Education Course on Shared-Decision Making

Getting There Together

- A continuation course for healthcare practitioners involved in the wheelchair evaluation process
- Integrates evidence of best practice in healthcare, wheelchair prescription, education, and behavior change
- Goal: Improve practitioners' confidence and competence in the implementation of SDM in their practice in wheelchair procurement to optimize person-technology fit to promote participation in mobility-related activities of daily living

Shared-Decision Making (SDM): A model for clients and clinicians to share the responsibility for medical treatment and decisions based on evidence-based practice [10]

- Effective assessment strategy to empower disadvantaged populations by increasing consumer accessibility to the process through the constructive communication of complex health information and collaboration between consumers and practitioners.

- Improved consumers' self-reports of satisfaction and agreement on treatment decisions across healthcare settings, including, in psychiatry, oncology, dentistry, internal medicine, cardiology, community care, neurology, pulmonary, endocrinology, surgery, gerontology and primary care [11, 12]
- Improved health outcomes for consumers with low socioeconomic status, low education/literacy levels, from geographically underserved locations, and/or are members of an ethnic minority group [13]

Details of the Program: *Getting There Together*

- In-person, three-part continuing education course delivered monthly in two-hour sessions focused on increasing practitioner confidence and competence implementing SDM
- Combines didactic and interactive formats, group and personal reflection, and goal setting based on concepts from the Adult Learning Theory and evidence-based literature regarding practitioner behavior change
- Course Objectives
  - Identify and describe the 3 steps of SDM
  - Increase self-reported confidence in use of SDM
  - Increase self-reported competence in the use of SDM
  - Increase self-reported use of SDM in practice
- Funding
  - Approximately $2,000 for implementation costs in first two years
  - Revenue generated from registration fees | $30 registration fee
  - Potential to save payers money due to decreased abandonment

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APPENDIX C: Example Session Outlines

Session 1: Introduction to Shared-Decision Making (TOTAL: 75 minutes)

See Appendix D for sample PowerPoint slides of Session 1 presentation with examples of roleplays, learning visual aids, etc.

Upon entering: participants will complete a pre-test focused on their confidence, competence, and knowledge of SDM. Each participant will be given a small binder with the paper copy of PowerPoint (3 slides per page with lines on right side) and notes pages to keep notes, write reflections, and set goals in.

- Facilitated Large Group Discussion (15 minutes; 5 per topic)
    1. Each participant introduces themselves/practice area/favorite occupation to begin creating a community
    2. Facilitated large group discussion of practitioners' current prescription and wheelchair evaluation processes
        a. How do you determine the appropriate wheelchair for consumers?
        b. What evaluation strategies do you use?
        c. Facilitator presents a synthesis of the input collected from the consumer focus group
    3. Guided reflection on consumer perspectives during the wheelchair evaluation process and the long-term outcomes of an inadequately prescribed wheelchair equipment. Example questions include:

a. What have consumers told you about their experience with wheelchair selection?
b. What has made the selection process easier or harder?
c. What are Mobility-Related Activities of Daily Living?
d. How does the type or fit of a wheelchair impact these ADLs?

- Instruction: Shared-Decision Making using PowerPoint as a visual aide (45 minutes)
    1. Principles of SDM
    2. History of the shift from paternalistic to collaborative models of care
        a. Small group reflection on potential impacts of the SD model on care, client impressions, and practice behaviors (5 minutes)
    3. Instruction: Team Talk
        a. Role play with partner (10 minutes; 5 minutes each direction)
        b. Partner reflection and feedback on performance with cues to take notes on personal strengths and weaknesses
    4. Instruction: Option Talk
        a. Role play with partner (10 minutes; 5 minutes each direction)
        b. Partner reflection and feedback on performance with cues to take notes on personal strengths and weaknesses
    5. Instruction: Decision Talk
        a. Role play with partner (10 minutes; 5 minutes each direction)

b. Partner reflection and feedback on performance with cues to take notes on personal strengths and weaknesses

- Goal Setting: SDM Implementation (15 minutes)
    1. Collaborate to create personal goals for the implementation of SDM into their practice. Participants will be cued to write the goals in their "field notes" notebook.

Session 2: Introduction to Shared-Decision Making (TOTAL: 75 minutes)

- Instruction: Review of SDM Three Talks (5 minutes)
    1. Review any questions.
- Guided Reflection and Discussion: SDM Implementation Goals (20 minutes)
    1. What facilitated goal achievement?
        a. What limited or hindered goal achievement?
        b. Do you any questions regarding SDM implementation?
    2. Collaborative group problem solving with cues to note helpful ideas or strategies in notebook.
- Instruction: Effective Communication using PowerPoint as a visual aide (35 minutes)

  Based on the principles of communication recommended for consumers with low-health literacy
    1. Recommendations to improve consumer comprehension: written material and verbal guidelines, and introducing the Teach-Back method.

a. Provider introduces and explains new information

b. Provider asks for consumer to repeat back the information in their own words and their perception on the shared information

c. Prover assess consumer's answer for information accuracy

d. Provider adapts messaging based on consumer's comprehension.

e. Repeat c and d until provider and consumer are comfortable with comprehension of the information.

2. Partner role plays (20 minutes; 10 minutes each) using Teach-Back method within "option talk" of SDM.
3. Partner reflection and feedback on performance with cues to take notes on personal strengths and weaknesses

- Goal Setting: SDM and Effective Communication Implementation (15 minutes)
    1. Collaborate to create personal goals for the implementation of SDM into their practice. Participants will be cued to write the goals in their notebook

APPENDIX D: Sample Slides from Session One

Getting There Together:

Shared Decision Making in Wheelchair Evaluations

Created by:
Emily D'Agostino, OTR/L

Introductions to the Group

1. Name
2. Area of practice
3. Two of your favorite occupations

This course is designed and facilitated by Emily D'Agostino.

Emily is a school-based Occupational Therapist based in San Francisco, CA. Her favorite occupations include hiking in the sun, and reading science fiction/fantasy books.

Current Practice

Large group discussion

1. How do you determine appropriate wheelchairs for consumers?
2. What evaluation strategies do you use?
3. What strategies have been effective? What have been a challenge?

Consumer Input

Insert sample consumer report from focus group

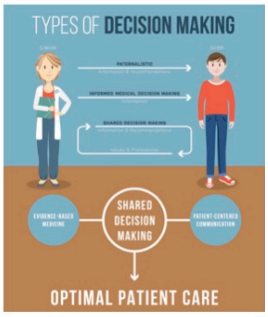
Process and Long-Term Outcomes

1. What have consumers told you about their experiences with wheelchair selection?
2. What made the process easier or harder?
3. What are Mobility-Related Activities of Daily Living?
4. How does the type or fit of a wheelchair impact these ADLs.

History

- Paternalistic Medicine
  - Treatment is prescribed based on clinician's gathered information, interpretation, personal or perceived preferences
- Disabilities Rights Movement
  - Nothing about us without us
- Shared Decision Making
  - Collaboration between clinician and consumer to arrive at treatment decisions that reflect consumer values, beliefs, and preferences

Joosten et al., 2008



Principles of Shared-Decision Making

- Treatment decisions are made **collaboratively** based on:
  - Trustworthy **information**
  - **Accessibly** presented options
  - Consideration of consumer and family **preferences, values,** and **beliefs**
- Practitioners should promote **consumer engagement** in their healthcare

Durand et al., 2014; Elwyen at al., 2017

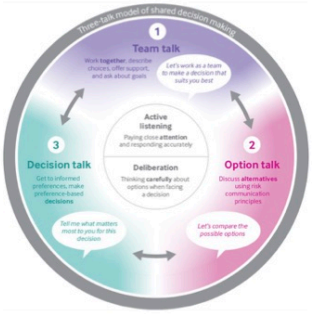
Team Talk

Purpose: Invite the consumer to the decision-making process

Goals:

1. Introduce **choices** related to wheelchair configuration, optimization, and features
2. Understand the **consumer's goals** for wheelchair use

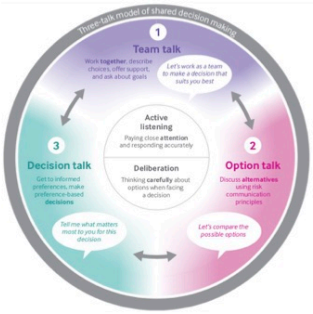
Elwyn et al., 2017



Team Talk

Roleplay

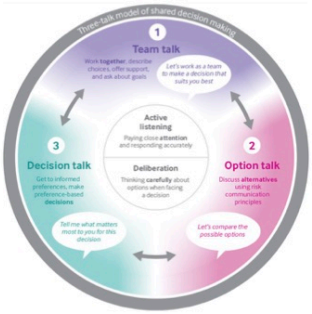
Karl is new to the wheelchair evaluation process. He was just prescribed a power wheelchair. He comes to see you for the wheelchair evaluation. Introduce the process using the principles of team talk.



Team Talk

Roleplay Reflection

- What went well?
- What was difficult?
- What felt the same?
- What felt different?



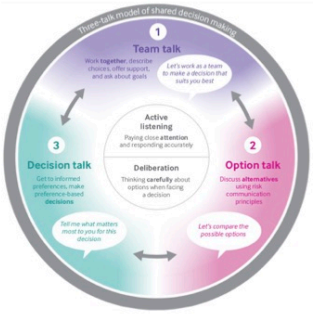
Option Talk

Purpose: Increase consumer knowledge of options

Goals:

1. Explain **clearly and concisely** the options available including relative advantages and disadvantages
2. Ensure consumer comprehension of the **benefits and costs** of each option

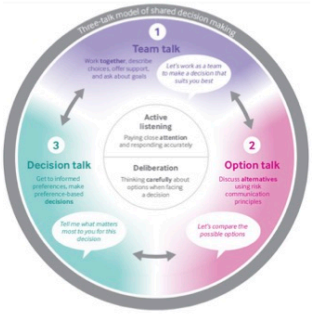
Elwyn et al., 2017



Option Talk

Roleplay

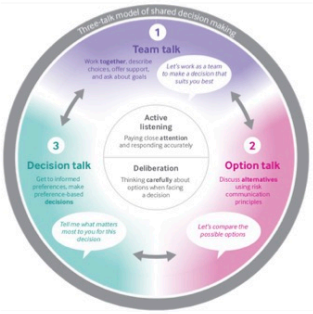
Explain to Karl the options of drive wheel positions (front-wheel, rear-wheel, or mid-wheel drive).



Option Talk

Roleplay Reflection

- What went well?
- What was difficult?
- Did you describe the options in a way that was clear and concise?
- How could you check to see if Karl understood?



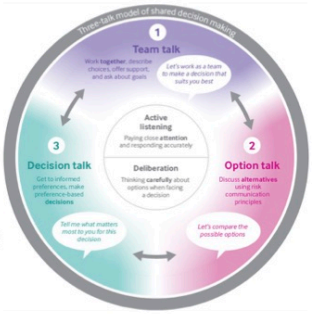
Decision Talk

Purpose: Facilitate the consumer to use the information to make a decision

Goals:

1. Facilitate consumer **processing and internalization** of the options
2. Consumer **makes decision** based on personal values, beliefs, and informed preferences

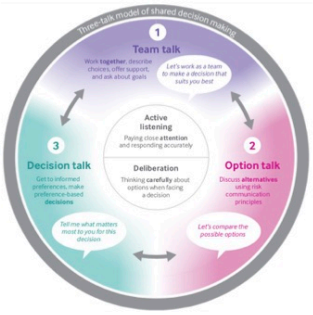
Elwyn et al., 2017



Decision Talk

Roleplay

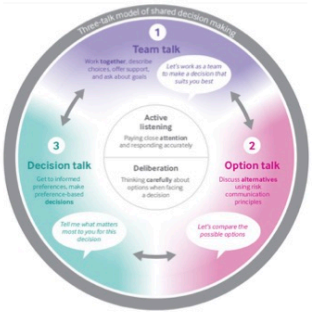
Help Karl decide which is the best option for drive-wheel position based on his goals.



Decision Talk

Roleplay Reflection

- What went well?
- What was difficult?
- What elements felt the same or different?



Goal Setting

Large Group Discussion:

- How might you like to implement Shared-Decision Making into your practice?
- How would you know if you were implementing SDM?

In your notebook:

- Write 2-3 personal goals for how you will implement SDM in your practice

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